

Children with Special Health Care Needs  
Reimbursement Rate Schedule

Service	Prior Authorization Requirements	Reimbursement Rate	Billing Guideline Reference
Audiology	Not Required	80% of UCR	5.1.2
Augmentative Communication Eval /Device	Required	90% of factory rate	8.12.0
Inpatient Hospitalization -Diagnostic Evaluation	Required for >5 days stay	Medicaid per diem	5.1.18
Inpatient Hospitalization -Treatment of Eligible Condition	Required for >14 days stay	Medicaid per diem	5.1.18
Facility Technical Component -Radiology -Pathology	Not Required	80% of UCR	5.1.25 5.1.22
Outpatient Clinic	Not Required	80% of UCR	5.1.21
Outpatient Surgery	Not Required	80% of UCR up to Medicaid inpatient per diem rate	5.1.25
Emergency	Notification required within 72 hours to determine eligibility	80% of UCR	5.1.11
Emergency Transportation	Notification required within 72 hours to determine eligibility	80% of UCR	5.1.12
Prescription Medications	Not Required Restricted to items on established formulary	UCR (up to AWP) minus 10%	5.1.20 5.1.23
Hemophilia Factor	Not Required	Medicaid Rate	5.1.17
Durable Medical Equipment (Rental)	Required	Negotiated thru prior authorization	5.1.9
Durable Medical Equipment Purchase (>\$500 total cost)	Required	90% of UCR	5.1.9
Durable Medical Equipment Purchase (<\$500 total cost)	Not Required	90% of UCR	5.1.9
Disposable Supplies	Not Required	90% of UCR	5.1.9
Durable Medical Equipment Repair	Required	90% of UCR	5.1.9
Ear Molds	Not Required	90% of UCR	5.1.10
Hearing Aids (>\$500 total cost)	Required	Wholesale cost + 10% Maximum	5.1.16
Hearing Aids (<\$500 total cost)	Not Required	Wholesale cost + 10% Maximum	5.1.16
Hearing Aid Accessories (>\$500 total cost)	Required	90% of UCR	
Hearing Aid Repair	Not Required	90% of repair charge + S/H in full	
Orthotic & Prosthetic Devices (>\$500 total cost)	Required	90% of UCR	5.1.9
Orthotic & Prosthetic Devices (<\$500 total cost)	Not Required	90% of UCR	5.1.9
Professional Fees - Inpatient -Anesthesiology -Pathology -Radiology -Surgical (including oral/dental surgeries) -Dental -Special Procedures -Emergency -Consultation	Not Required	<\$100 - In Full Balance >\$100-54% Maximum Reimbursement \$800	5.1.15 5.1.1 5.1.22 5.1.25  5.1.5
Dental -General Dentistry	Not Required	80% of UCR	5.1.8
Dental -Orthodontic Procedures	Required	80% of UCR	5.1.8
Office Visit -Radiology -Pathology -Special Procedure	Not Required	80% of UCR	5.1.19
Office Visit -Professional Fee	Not Required	\$15 for established patient \$60 for new patient	5.1.19
Outpatient Clinic Visit -Radiology -Pathology -Special Procedure	Not Required	80% of UCR	5.1.19 5.1.25 5.1.22 5.1.19
Outpatient Clinic Visit	Not Required	\$8 for established patient	5.1.21

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-Professional Fee		\$25 for new patient	
Speech/Language Evaluation	Not Required	\$42/hour	5.1.13
Speech Therapy (Individual)	Required for >5 hours of individual and/or group combined/week	\$42/hour	5.1.13
Speech Therapy (Group)	Required for >5 hours of individual and/or group combined/week	\$14/hour	5.1.13
Occupational Therapy Evaluation	Not Required	\$42/hour	5.1.13
Occupational Therapy	Required for >5 hours/week	\$42/hour	5.1.13
Physical Therapy Evaluation	Not Required	\$42/hour	5.1.13
Physical Therapy	Required for >5 hours/week	\$42/hour	5.1.13
Respiratory Therapy	Required for >5 hours/week	\$42/hour	
Psychological Evaluation	Required	\$60/hour	5.1.13